

Real Life Fellowship - Consent to Medical Care for a Minor

By signing this form, I (we) hereby authorize **Real Life Fellowship or its designee** to consent to any medical care and treatment for _____ (Child) that is recommended by a licensed healthcare provider to whom the Child is presented for treatment. In order to ensure that the Child receives prompt medical care and treatment when necessary, I (we) hereby release any licensed health care provider providing medical care to the Child in reliance of this form from liability relating to such provider's acceptance of my (our) substitute care giver's consent.

Parent's (or Guardian's) Signature Date (optional)Second Parent's Signature Date

Medical History

Child's Name Child's Birth Date Allergies (including food & medication)

Blood Type (if known) Date of Last Tetanus Shot (if known)

Previous Hospitalizations and Major Illnesses Current Medications

Doctor's Name Telephone Other Important Information

Insurance Information

Insurance Company Policy Number Plan #

Claim Office Address Claim Office Phone Number

Other Information

Name of Parent(s) or Guardian(s) Home Address

Home Phone Work Phone Cell Phone

In case of emergency, we will first call the numbers above. If no answer, will will contact the following:

Name/Relationship to Participant Phone Number (INCLUDE AREA CODE)